INSTITUT C.D. HOWE INSTITUTE

COMMENTARY
NO. 443

# Shifting Towards Autonomy: A Continuing Care Model for Canada

*Faced by chronic health problems or just old age, seniors require supportive services but worry about their affordability and access to them. International experience suggests that self-directed care options can achieve better autonomy for dependent elderly.*

Åke Blomqvist and Colin Busby

## About The Authors

Åke Blomqvist
is an Adjunct Research Professor at Carleton University and Health Policy Scholar at the C.D. Howe Institute.

Colin Busby
is a Senior Policy Analyst at the C.D. Howe Institute.

## The Institute's Commitment to Quality

C.D. Howe Institute publications undergo rigorous external review by academics and independent experts drawn from the public and private sectors.

The Institute's peer review process ensures the quality, integrity and objectivity of its policy research. The Institute will not publish any study that, in its view, fails to meet the standards of the review process. The Institute requires that its authors publicly disclose any actual or potential conflicts of interest of which they are aware.

In its mission to educate and foster debate on essential public policy issues, the C.D. Howe Institute provides nonpartisan policy advice to interested parties on a non-exclusive basis. The Institute will not endorse any political party, elected official, candidate for elected office, or interest group.

As a registered Canadian charity, the C.D. Howe Institute as a matter of course accepts donations from individuals, private and public organizations, charitable foundations and others, by way of general and project support. The Institute will not accept any donation that stipulates a predetermined result or policy stance or otherwise inhibits its independence, or that of its staff and authors, in pursuing scholarly activities or disseminating research results.

Commentary No. 443
January 2016
Healthcare Policy

*Daniel Schwanen*
*Vice President, Research*

$12.00
ISBN 978-0-88806-966-5
ISSN 0824-8001 (print);
ISSN 1703-0765 (online)

## The Study In Brief

For many seniors, their greatest health concern is the ongoing care that many of them will need as their ability to cope with the routine tasks of daily life declines. Due to various chronic health problems or just old age, supportive services for seniors – often referred to as continuing care – encompass a wide range of needs, from help with daily meals in patients' homes to institutional care for those with major cognitive or physical disabilities. On this score, many Canadians have expressed concerns about affordability and access to care in their desired location.

The state of continuing care in Canada is troublesome on a number of fronts, including the rising stress on caregivers, long waits for nursing home beds, and unmet homecare needs. More than one in four Canadians provide care to family or friends, and among this group one in 10 provides more than 30 hours weekly, often with significant disruption to their paid work. It has been estimated that more than 15 percent of all acute-care hospital beds in Canada are filled every day with patients waiting for care in a location outside a hospital, costing provincial governments slightly under $3 billion per year. And although there has been an increase in subsidized care in people's homes in recent years, the provinces appear to be well behind the international trend in this regard and will struggle to keep pace with rising demand.

Canada's provinces can learn important lessons from the debates and reforms in other developed countries. A number of them have faced the same challenges but have been much more proactive in establishing a framework for supporting greater independence among the elderly. In doing so, they have recognized that shifting more services to the home and community is a key goal.

The experience abroad shows several countries, such as France, Germany and recently Australia, have implemented self-directed models of care delivery, boosting patient satisfaction by giving individuals and families a greater say in their care packages. Two of the biggest challenges for governments contemplating more cash-based, self-directed benefits for continuing-care services are impact on government budgets and quality assurance. All countries we studied have, however, managed to overcome these challenges, at least to some degree, through restrictions on the size of the subsidy to those with substantial means or available family help and by establishing oversight in the use of the cash subsidies.

In the study, we sketch a provincial continuing care model that would draw on these countries' experience. Establishing a new comprehensive self-directed model along the lines we propose will require:

- an assessment system;
- means testing;
- a funding mechanism that is based on need but controls government costs;
- an oversight system to ensure quality and enforce restrictions on use; and,
- establishing who will oversee, coordinate and be accountable for care.

The time to adopt new systems of supportive services for the elderly is now – before many more retiring babyboomers start drawing heavily on them.

---

*C.D. Howe Institute Commentary*© is a periodic analysis of, and commentary on, current public policy issues. Michael Benedict and James Fleming edited the manuscript; Yang Zhao prepared it for publication. As with all Institute publications, the views expressed here are those of the authors and do not necessarily reflect the opinions of the Institute's members or Board of Directors. Quotation with appropriate credit is permissible.

To order this publication please contact: the C.D. Howe Institute, 67 Yonge St., Suite 300, Toronto, Ontario M5E 1J8. The full text of this publication is also available on the Institute's website at www.cdhowe.org.

## In surveys of what Canadians expect from their governments, healthcare consistently tops the list.

For those contemplating their old age, they want government to make sure that the health services and drugs they need will be readily available, at a cost they can afford. Most are aware that, with aging populations, this task will put pressure on provincial governments' budgets, but the principle that public funds should finance healthcare is well established, and Canadians expect their elected representatives at the federal and provincial levels to raise enough revenue to do so.

Indeed, the *Canada Health Act* (CHA) mandates that public funds should cover physician and hospital services for every resident. While the CHA does not apply to outpatient pharmaceuticals, public coverage of prescription drug costs for seniors has, over the years, become the norm: most provinces now have programs under which residents over age 65 have to pay only a relatively small share of their drug costs.

But for many seniors, their greatest concern is neither physician nor hospital services, nor drugs, but instead the ongoing care that many of them will need as their ability to cope with the routine tasks of daily life declines as a result of various chronic health problems or just old age. These supportive services go by many names, but are commonly referred to as "continuing care," which encompasses a wide range of needs, from help with daily meals to support for those with major cognitive or physical disabilities, and may be provided either in the patient's home or in an institution such as a nursing home.[1]

Much of seniors' apprehension relates to affordability. Even though all provinces have programs that subsidize continuing care to some extent – be it at home or in an institution – it is not covered by the CHA, so patients usually have to pay part of the costs out-of-pocket. Depending on the province, patient co-payments can be substantial. Although Canadians may be aware of this, generally speaking, many do not realize how large these costs may be in cases where an elderly person needs substantial care, especially when it is needed over a long period of time. As a result, there have been calls for increased government subsidies to better protect patients against the financial hardship that can arise in such cases (Grignon and Bernier 2012).

Apart from cost, seniors also worry about access to care. In most provinces, there are waiting lists – often long ones – for places in subsidized long-term care homes. Moreover, surveys have shown that seniors generally consider institutional care as a last resort and prefer to receive care in their own homes for as long as possible. In response, provinces have expanded their subsidized homecare programs over the years, but even when it is available, homecare is typically rationed and many seniors face unmet needs (Turcotte 2014). Many OECD countries are well ahead of Canadian provinces in shifting

The authors would like to thank the many anonymous reviewers and members of the C.D. Howe Institute's Health Policy Council who provided comments on this paper. Any errors and opinions are the responsibility of the authors.

1 There is a range of terms to describe continuing care. Australia and the UK call it "aged care;" the World Health Organization uses the term "long-term care." But because the term long-term care in most Canadian provinces conventionally applies to care in traditional institutions, such as nursing homes, in this *Commentary* we use the term continuing care to highlight the spectrum of care needs.

continuing-care resources toward patients' homes or to other forms of retirement living, away from traditional long-term care institutions.

Rationing and wait lists can impose large indirect costs on patients and their families. And they are a burden for the acute-care system: it has been estimated that more than 15 percent of all hospital beds in Canada are filled every day with patients waiting for care in a location outside a hospital (Sutherland and Crump 2011) and that more than 2.4 million annual hospital bed days are attributable to such patients, 85 percent of whom are aged 65 and older. A conservative, national estimate of the resulting costs to provincial governments is slightly under $3 billion per year.[2]

Responding to these concerns will be expensive. Aggregate estimates for Canada as a whole put the costs of institutional elderly care under subsidized provincial programs at some $24 billion in 2014, roughly 10 percent of total healthcare spending. Privately borne costs, consisting of patient co-payments for subsidized services as well as services purchased privately, along with the imputed costs of care supplied without pay by family members and others, have been estimated at $44 billion (Blomqvist and Busby 2014, 8).

Even with an unchanged degree of public subsidization, government costs are expected to rise rapidly over the next several decades. One estimate shows the public costs of continuing care rising from 1.3 percent of GDP in 2014 to around 2 percent by 2040, even if the public-private split of the total remains unchanged (Blomqvist and Busby 2014, 8).[3] Raising the necessary revenues to pay for these costs will be a challenge, as an aging population also raises the demand for acute-care services and drugs, and leads to relatively fewer working-age taxpayers. Increasing the degree of subsidization (that is, raising the government's share of total continuing-care costs) will make the challenge even more daunting.

The rising stress on caregivers is another troubling indicator of the true cost of health services for the elderly. More than one in four Canadians – about 28 percent, or nine million people, most of whom are women – provide care to family or friends. While most supply fewer than 10 hours of care per week, one in 10 provides more than 30 hours weekly, often with significant disruption to their paid work (Sinha 2013). Family caregivers will continue to make up the most important source of care for seniors in need, even as there is growing pressure on them to balance their daily priorities and avoid financial stress.

Meanwhile, Canada's provincial models of financing and managing continuing care have developed with little discussion about what principles could be applied to create a nationwide network of programs to ensure equitable access at a reasonable cost. In a number of other countries, in contrast, these issues have been actively debated for a long time, and their continuing-care models have been reformed – quite dramatically in several cases. In comparison, our provincial approaches are beginning to look not only inefficient and unresponsive to individual preferences but also, in some dimensions, inequitable.

2 This estimate is based on acute-care bed costs of approximately $1,200 per day. More recent nationwide estimates for alternate level-of-care patients were not available at the time of writing, but we anticipate that the figure for 2015 will be higher than the 2.4 million hospital bed days estimate in 2008/09, the latest available one.

3 A recent Conference Board of Canada study reports similar findings even though it used a different methodology. Stonebridge, Hermus and Edenhoffer (2015) estimate that "spending on continuing care for seniors will increase from $29.3 billion in 2011 to $184.2 billion in 2046. With nearly two-thirds of this spending provided by governments, spending growth will significantly outpace revenue growth for most provinces."

In this *Commentary*, we argue that Canada's provinces can learn important lessons from the debates and reforms in other developed countries. Specifically, it is notable that the vast majority of advanced nations have moved to continuing-care models that give patients a much larger say in the suite of services that they receive – and where. They accomplish this by offering individuals the option to receive a cash payment, or a cash payment with restrictions on use (a voucher), which allows them to purchase services that are delivered where they want them. This is often referred to as "self-directed care." The expectation is that those who can afford it will pay part of the cost themselves, but all elderly persons with a given level of disability are guaranteed some basic level of coverage.

We urge Canadian provinces to adopt these approaches, and to do so now, before the large number of retiring baby-boomers reaches the age (around 80) when many of them will start drawing heavily on the system. Although many provinces have developed small scale self-directed care programs, this *Commentary* outlines a broader strategy for moving to an equitable, comprehensive self-directed system that controls costs while ensuring service quality.

## The State of Continuing Care in Canada: "One-Size-Fits-All"

Provinces differ in the extent to which they subsidize home and long-term care services for the elderly, but the overall models are very similar (Stadnyk 2009). When it comes to institutional care, most provinces claim to distinguish between healthcare costs, such as the services from case managers, nurses, physicians and personal care workers, and the costs of lodging and associated costs like food and housekeeping. In doing so, the intention is to set private copayments according to the costs of lodging that would otherwise be borne privately, were the patients living in the community.

The cost of services delivered by health professionals is supposed to be covered publicly as the services are similar to those within our medicare system.[4] Limited copayments for many homecare services are treated the same way in the sense that most nursing services are covered publicly but other services for less acute personal needs are borne privately. With fixed copayments, governments pay the residual costs of the services that patients receive.

On the supply side, there is a mixture of public, private not-for-profit and private for-profit providers of home, community, retirement home and other institutional services in provinces across the country. Most homecare nursing services are delivered through public sector employees, while personal care services are often supplied through contracts with private providers.[5] Available care is allocated mainly based on need, with centralized and often regional waiting lists. In contrast to most other OECD patients, Canadians have very little control over the bundles of services available to them. Although some Canadian provinces have allowed for small scale models of self-directed care based on cash subsidies in recent years (Fast 2015), nearly all services are provided "in kind."

Importantly, Canadians may also purchase unsubsidized services – be they in a home,

4 In practice, there are reasons to think that this principle is not strictly adhered to (Canadian Home Care Association 2009), mainly because patient charges vary so much across provinces that some of the differences must be explained by costs over and above the cost of lodging.

5 Ontario differs from most provinces by having contracts with private providers for a wide range of services (Canadian Home Care Association 2013). For a discussion on the state of homecare in Ontario, see the recent Report of the Expert Group on Home and Continuing Care (Donner Report 2015).

institution or retirement residence – from private providers who manage their own waiting lists and charge fees without government intervention. The size of the unsubsidized aged-care sector is significant – Canada's 2012 census estimates that among those aged 65 and older living in collective dwellings (about 400,000 in total), 43 percent lived in residences for senior citizens or "other collective" settings, with the remainder living in subsidized nursing homes, chronic-care facilities or long-term care hospitals.[6]

The major flaws in Canada's approach to providing supportive services to dependent elderly – such as inappropriately long hospital stays, underserved homecare patients and stress on family caregivers – occur partly because of the focus on providing care in institutions and the painstakingly slow process of moving care to the community. In 2013, the provinces, territories and federal government spent an estimated $6 billion on homecare (Canadian Home Care Association 2013). As a percentage of health spending, homecare averaged 4 percent of all health costs, ranging from a high of 6.8 percent in New Brunswick to a low of 2.4 percent in Alberta.

Other OECD countries, on average, spend a much larger share of their health and long-term care budgets on homecare services than Canada (OECD Stats 2012),[7] as they have shifted large shares of their health budgets towards delivering care to the frail elderly in their homes. But even though there has been an increase in subsidized care in people's homes in Canada as well, the provinces appear to be well behind the international trend and likely will not keep pace with the demand for homecare. What is it that makes other countries' models of supporting dependent elderly so different from Canada's?

## International Models for Supporting Dependent Elderly

Like Canada, many OECD countries face high rates of population aging as a result of a postwar baby boom. Increasing numbers of elderly are putting pressure on hospitals, caregivers and government budgets. And because each individual has unique care needs, governments are under pressure to meet varied patient demands. We look at the systems of financing and delivering care for seniors in need of assistance among countries that have similar characteristics to Canada in some respects, but which also represent a diverse group of health-system models.

Specifically, we look at continuing-care systems in Germany, France and Australia.[8] We chose the first two countries because they have different approaches to organizing and financing – Germany with a long-term care social insurance system and France with a split between private payments and financing out of general government revenue. And we chose Australia because of its broad similarities to the Canadian approach to continuing care – with a history that saw programs develop in an ad hoc manner and with overlapping federal and state roles and responsibilities.

6 Across Canada, a number of privately owned assisted living facilities are publicly subsidized to differing degrees, which means that the percentage of seniors living in unsubsidized facilities is less than the 43 percent estimate.

7 The OECD data on long-term care spending in Canada do not show provincial spending on homecare services, so these overall numbers are understated. Nonetheless, given the magnitude of homecare spending differences between Canada and other OECD nations, the general observation that Canada spends relatively less appears to be correct.

8 Initially, we also examined the continuing-care system in Sweden as well as in a number of other advanced nations. However, we trimmed the text so as to focus on the three systems that we felt held the most important lessons for Canadian policymakers.

*Germany*

For most of the post-war era, informal care by family members was the main form of dependent elderly care. But in 1995, Germany introduced a mandatory insurance scheme for old-age healthcare services. All workers make compulsory contributions of some 2 percent of payroll income (employers contribute 1 percent) in return for eligibility to receive continuing-care benefits when they turn 65, or earlier if needed. Seniors eligible for benefits can receive care either in the form of a cash voucher or through in-kind services, with care paths determined by health professionals (Shultz 2010). The default option is in kind, which means that people must actively opt out to receive a cash voucher.

Those who qualify for benefits, which are not means tested, are elderly with a physical, psychological or mental handicap who require help to carry out daily routines over a minimum six-month period. Eligibility includes the need for hygiene, nutrition, mobility, housekeeping, etc.

There are three levels of assessed care needs. Level I is for those who need minor help with personal care and mobility and a basic amount of nursing help. The highest level, Level III, means that a patient requires regular help and assistance and significant nursing help daily (see Table 1A). The total benefits vary depending on whether one receives care at home or in an institution, with the intent to encourage more homecare substitution (see Table 1B).

Benefits vary by need and place of care. Benefits provided in cash are smaller than what they would cost were they provided in kind, implying additional out-of-pocket payments are required. Special hardship cases will be considered for additional funding.

Among the roughly 2.3 million beneficiaries in 2012, more than 1.9 million, or 80 percent, were aged 65 and up. Eleven percent of all seniors qualified for benefits, with the proportion rising from around 3 percent for those aged 65 to 69 to around 60 percent for those aged 90 and older (Schölkopf 2013).

About 70 percent received care at home with roughly 80 percent of those choosing the cash option (Schölkopf 2013). Cash benefits are given directly to the dependent person, who spends it with oversight by case coordinators and personnel to ensure recipients get sufficient care. Cash benefits may be passed on to informal family caregivers and such transfers are not considered taxable.

*France*

Major changes began at the turn of the 21st century following two decades of public policy debate. Among its reforms, France abandoned the term "long-term care" and embraced instead a nomenclature of policies toward dependent elderly that emphasized "maintaining autonomy." To avoid putting too much pressure on already strained public finances, the current framework for the French continuing-care system is based on a "French Compromise," striking a balance between public and private funding sources (Le Bihan and Martin 2013).

In 2000, France introduced the Personal Allowance for Autonomy (APA), which provided public support for "dependent elderly" aged 60 and older in the form of a monthly cash allowance. With cash payments going directly to dependents, it was the largest addition to France's continuing-care framework in recent history, covering more than 1.2 million recipients in 2012, nearly 10 percent of those aged 60 and up.[9] Major rationales behind the cash-for-care model were to improve

9 Former President Nicholas Sarkozy referred to old-age dependency as the "fifth risk" of the French social security safety net.

**Table 1A: Care Needs and Required Services in Aged-Care, Germany**

| | Care Level I – Need for Considerable Care | Care Level II – Need for Intensive Care | Care Level III – Need for Highly Intensive Care |
|---|---|---|---|
| **Help with personal care, nutrition or mobility** | At least once a day for at least two tasks in one or more areas | At least three times a day at different times of the day | Assistance around the clock |
| **Additional assistance** | Several times a week in taking care of the household | Several times a week in taking care of the household | Several times per week in taking care of the household |
| **Nursing staff needs** | At least 1.5 hours/day on the average | At least 3 hours/day on the average | At least 5 hours/day on the average |

Source: Schölkopf (2013)

**Table 1B: Size of Monthly Homecare Benefits (Cash and In-kind), Germany**

| | Benefits in Euros, 2012 | | |
|---|---|---|---|
| **Category of Care** | **Home Care (cash)** | **Home Care (in kind)** | **Institutional Care (full time)*** |
| **Level I** | 235 | 450 | 1,023 |
| **Level II** | 440 | 1,100 | 1,279 |
| **Level III** | 700 | 1,550 | 1,550 |

Note *special hardship request possible.
Source: Schölkopf (2013).

support for both formal and informal care, cost containment and increased choice for users (Le Bihan and Martin 2013).

Individuals are assessed for level of disability by a medical and social services team composed of at least one doctor and social worker. Home visits are required to determine overall needs. Those determined to require care are classified according to six levels,[10] with the four highest leading to an assistance plan that may include home help or aid for transportation or meal delivery (see Table 2A).

10 See http://www.cnsa.fr/documentation/guide_aggir_2008.pdf.

The cash benefit is both needs and means tested. The minimum qualifying category of care covers people with average or above-average dependency levels. In 2014, the maximum monthly amounts were approximately 1,300 euros (approximately $2,000) for the highest level of dependency, dropping to 550 euros ($850) for the lowest level (see Table 2B). Funding for institutional care is based on the costs of 1) accommodation, to be paid by individuals or by social assistance, 2) expenses linked to dependency, which is paid for by the APA and resident copay and 3) the cost of healthcare, which is paid for by public health insurance. Over 60 percent of all APA recipients receive care in their homes (see Table 2B, Columns 3 and 4). Surprisingly, there is a large amount of homecare substitution, even for those with higher levels of needs.

A key feature of the French aged-care model is that the benefit is paid to finance a specific care package determined by a team of professionals according to the recipient's needs. Benefits can only be used to pay for services identified in the package. Paid carers can be professional workers or relatives, except for spouses. The aim is to create choice and get family involved in arrangements regarding care decisions, even though the type of care is determined by case workers and professionals. Control of the benefit helps to ensure greater regulatory oversight – most other European countries do not have similar controls (Ungerson and Yeandle 2007).[11] Services are supplied under a "quality agreement," which ensures that recipients are seeking out care from qualified workers when looking outside their families for care.

The cash allowance is intended to cover only a share of overall disability-related costs – individual contributions are expected to pay for the rest. Individuals earning less than $1,050 per month are not expected to contribute financially to their care packages, but copayments apply for those with incomes above this amount. Those earning more than $4,130 monthly are expected to pay 90 percent of the cost – or, in other words, receive only 10 percent of the maximum subsidy (France 2015).

Many French citizens have insured against the need for private co-pays and top-up coverage, particularly for high-dependency scenarios. With well over three million policyholders, France has the largest per capita market for private long-term care insurance, growing at 15 percent annually over many years (Columbo et al. 2011).[12,13]

### *Australia*

Australia's continuing-care system, "aged care," has developed in an ad hoc manner since programs of home and community care services were established in 1985. Over time, the list of aged-care services that were publicly financed grew and the scope of care packages expanded to meet the growing and varied demand. The main current programs, Community Care Packages and Extended Aged

11 The Netherlands, which has a similar cash voucher for continuing-care services, arguably imposes even greater usage restrictions than France. For example, even if care is to be provided by a family caregiver who is paid by the cash benefit, recipient and provider have to agree to a formal contractual relationship.

12 France recently introduced a "recovery from inheritance" provision that would ensure that part of the APA will be recovered, upon death, from inheritances of well-off families. An alternative is that APA recipients could choose to receive 50 percent of their allowance without inheritance recovery.

13 Another French reform goal was to grow employment in the health-services industry. The original scheme was developed in three prongs: 1) case workers would help to purchase care from qualified professionals; 2) individual recipients would purchase care from qualifying non-profit or public organizations; and 3) individuals would enter into an agreement with their chosen care provider.

**Table 2A: Assessed Categories of Care**

| | Applicant Characteristics – Degrees of Dependence |
|---|---|
| **Level 6*** | Autonomous for essential activities of daily life. |
| **Level 5*** | Person who may only need occasional help with toileting, meal preparation and housekeeping. |
| **Level 4** | Some mobility limitations, but can move within his or her housing; needs aid for washing and dressing; or person having no mobility problems but must be helped for body care and meals. |
| **Level 3** | Person with mental autonomy,but who needs daily and several times a day to help for personal care. |
| **Level 2** | Person confined to bed or chair, whose mental functions are not fully impaired and whose condition requires support for most everyday activities; or a person whose mental functions are impaired, but is able to move and requires constant monitoring. |
| **Level 1** | Person confined to bed or chair, whose mental functions are severely impaired and requires an essential and continuous presence of caregivers. |

Note: Levels 5 and 6 do not qualify for benefits, but are still used for assessing care needs.

**Table 2B: Maximum Benefits and Recipient Shares, by Location and Category of Care**

| Category of Care | Monthly Max. in Euros, 2014 | Recipients in Home | Recipients in Institutions |
|---|---|---|---|
| | | *percent of all recipients* | |
| **Level 4** | 565 | 36 | 9 |
| **Level 3** | 845 | 13 | 6 |
| **Level 2** | 1,125 | 11 | 18 |
| **Level 1** | 1,315 | 2 | 6 |

Source: France (2015) and Le Bihan and Martin (2013).

Care at Home, began in the early to mid-90s. Such care covers five main areas: supporting informal care, preventing residential care, substituting for residential care, residential care itself, and catering to diversity (Australia 2014).

There is federal oversight of funding, but programs are delivered at the state or local level. There is a simple formula-based metric in place to finance suppliers of care, be they public, non-profit or for-profit (see Table 3). The formula calculates the severity of one's disability based on three factors: 1) need for assisted daily living, 2) behavioural and cognitive needs and 3) complex health requirements such as the need for assistance in taking medication. It then associates a level of public subsidy with disability scores.

Public funds are regionally allocated according to age-based formulas that take account of factors such as the ratio of individuals aged 70+/1,000 persons in each region. There is a 60/40 funding split between the federal government and states.[14] Care packages are available to all but subject to a means test, which accounts for both income and assets (Australia 2014).

The government has attempted to control the composition and supply of care, mainly to maintain fiscal control over the continuing-care system, but this has resulted in numerous problems – inefficiencies resulting from misallocation of resources, waiting lists and poor quality. Critics say limited resources are forcing agencies mainly to serve clients with high dependency needs, to the detriment of providing low-level preventative care to people with less severe problems.

These concerns have led to reforms (beginning in 2015) that introduce more consumer-directed care with more say by users over how care is delivered (and how public monies are spent). Two factors – the uncertainty of projections on demands for specific kinds of aged care as well as the desire to improve the ability for seniors to remain at home – are the major reasons why Australia has embraced the notion of cash for care.

Consumer-directed care intends to give recipients more say in the services accessed, how they are delivered and who delivers them. All participants work in partnership with service providers to develop a care plan – a family member or carer can help co-design care packages – where service providers monitor and provide formal reviews to ensure that care needs are met. Service providers must also issue monthly statements to show how budgets are spent.

Private copayments are intended to top up the basic cash subsidy. There are means tests to copayments, as well as annual and lifetime caps. Early measurement of the consumer-directed programs has proven inconclusive in terms of cost-efficiencies but has demonstrated a notable increase in patient satisfaction (Australia 2013).

### Summary of International Models and Lessons for Canada

Schemes that allow the elderly to choose between care in kind or a cash subsidy, or restricted cash transfers, have become a widely accepted feature in most developed nations as they seek to promote more independent living. Self-directed care is common within European countries (Pavolini and Ranci 2013, Ungerson and Yeandle 2007),[15] and it is now becoming a larger part of continuing care in

14 But policy and funding responsibility is being transferred from the states back to the commonwealth (the federal government) to promote national standardization among continuing care, health and disability systems.

15 We were somewhat surprised by the significant role played by consumer-directed, cash-for-care models in countries originally selected for study, so we looked at others to see if they also applied this model. We found important cash-for-care models in place in the Netherlands, Austria, Italy, many Nordic countries as well as in some parts of the US.

**Table 3: Australia's Continuing care Funding Instrument: Levels of Care and Subsidy**

| | (Care level) Score Calculation | | | | | Funding per Day |
|---|---|---|---|---|---|---|
| | *A (low) to D (high)* | | | | *Total Score* | |
| **Assisted Daily Living Subsidy** | A | B | C | D | | |
| Nutrition (readiness to eat) | 0 | 7 | 13 | 20 | >18 = Low | $31 |
| Mobility | 0 | 7 | 14 | 21 | >62 = Medium | $68 |
| Hygiene (dressing, washing) | 0 | 7 | 14 | 21 | >88 = High | $95 |
| Toileting | 0 | 6 | 12 | 18 | | |
| Continence | 0 | 6 | 12 | 17 | | |
| **Behavioural Subsidy** | | | | | | |
| Cognitive skills | 0 | 7 | 14 | 21 | >13 = Low | $7 |
| Wandering | 0 | 6 | 12 | 18 | >30 = Medium | $15 |
| Verbal | 0 | 7 | 14 | 21 | >50 = High | $31 |
| Physical | 0 | 8 | 15 | 23 | | |
| Depression | 0 | 6 | 11 | 17 | | |
| **Complex Health Subsidy** | | | | | | |
| Medication (assistance required) | 0 | 1 | 2 | 2 | =1 = Low | $14 |
| Complexity (procedures) | 0 | 2 | 3 | 3 | =2 = Medium | $40 |
| | | | | | =3 = High | $58 |

Source: Australia (2014). The current exchange rate is roughly $1Aus. = $1 Can.

Australia. Given the evolution of other systems of supportive services for dependent elderly, Canadian provinces, even with some small-scale cash-based options emerging (Fast 2015), are becoming outliers when it comes to widely embracing self-directed care.

The rationales for introducing a greater reliance on cash-based, self-directed models vary. They include:

- increased recognition of diversity in care needs and the slow responsiveness of publicly managed care to these needs;
- homecare substitution and preference over institutional care;
- the need to put health costs on a more sustainable path;
- the need to ensure choice;
- the desire to improve the consistency of care for all people with similar needs;
- the desire to better incorporate informal caregiving into care plans;
- the desire to introduce more competition into care markets;
- job growth in caregiver services;
- the importance of promoting independence among the elderly; and
- the desire to remove the distinction between age-related disabilities from overall policy toward those with disabilities.

Although there are not yet any studies showing improved cost-efficiencies from moving to self-directed and increasingly cash-based systems, patient satisfaction has gone up considerably in places where cash subsidies have been introduced (Australia 2013, Columbo et al. 2011).[16] In almost all these countries, individual choice is recognized as an important feature in maintaining and promoting autonomy among the elderly.

Moreover, there is considerable variation in how countries have gone about introducing self-directed, cash-based models in terms of means tests, the way in which care needs are assessed and how to ensure quality through restrictions and oversight of the way moneys are spent. Some countries, like Germany, are more inclined to give cash benefits with few restrictions, but they set the size of the cash benefit below the value of in kind services as a way of steering individuals toward the in-kind option. In contrast, France and others, such as Japan, give cash benefits but with greater restrictions, making them more like vouchers. Canada is unique in offering little choice and largely restricting provision to services in kind.

All countries have grappled with the potential fiscal implications of their programs, controversy over the rules determining benefits and concerns around the ability of the elderly to act as informed customers. Furthermore, given the inertia of health systems, a key question is how to implement a self-directed model and change the existing system. In the following section, we sketch out what an ideal model might look like in Canada and how it might be implemented, taking into account existing services and structures, cost issues, and concerns over quality.

## Elements of the Proposed Model

The blueprint we suggest is intended to bring provincial continuing-care systems closer to the ideal under which everyone who needs it should have access to a basic level of care, even those with little or no ability to pay. Access in this context also means no lengthy wait times. A secondary objective is to accomplish reforms in a way that takes account of current fiscal pressures, which only will grow worse as populations age and the

16 Even the US has experimented with cash-for-care models for the elderly, with similar positive results for patient satisfaction and no observable declines in quality of care (see Carlson et al. 2007; Wiener, Anderson and Khatutsky 2007).

share of working-age taxpayers becomes smaller. Finally, the model is intended to come closer to the ideal of being centred around individual needs, in the sense of giving as much room as possible for patients to make choices that reflect their personal circumstances and preferences.

More concretely, the model draws on the French and Australian experiences in being based on a set of subsidies that potential recipients are eligible for; the amount of subsidy depends both on the patients' need for care and their ability to pay. Furthermore, it draws on the German approach in giving patients a choice between receiving care in kind (that is, from providers who either are owned and operated by government, or from suppliers under government contracts) or receiving the corresponding subsidy in cash or as a voucher, in which case patients and their families assume greater responsibility to purchase the required care from independent providers. We also discuss how restrictions on cash or voucher use, and staged implementation of the model along with professional oversight can address the crucial concerns over how a high quality of care can be maintained in a system with more patient and family autonomy.

The model we propose has three basic building blocks drawn from the systems in France, Germany, and Australia. The first is classifying the dependent elderly according to what types and amounts of care they should be entitled to, regardless of their ability to pay, and estimating how much it would cost to provide this care. The second is a set of rules that specify what part of the expected cost should be paid by the patients themselves; as in France, these amounts would be means-tested. Finally, the third building block would specify the rules under which patients could choose to receive a cash subsidy (rather than benefits in kind) and how they would be allowed to spend it.

## Classifying Patients: Universal Access to Care-needs Assessments

Assessment of patients' care needs already is part of every provincial system. In our model, the evaluation should depend only on the patient's health status and ability limitations; i.e., criteria such as financial circumstances and availability of informal care should not be relevant at this stage.

Since the objective of the classification process is to determine the subsidies that should be offered in different needs categories, the starting point must be the cost of providing acceptable care in each category. In general, these costs will depend not just on the patients' degree of disability, but also on the nature of the health problems from which they suffer.[17]

Many provinces use the Method for Adjusting Priority Levels (MAPLe) or Resource Utilization Groups (RUG-III) as a screening tool to classify individuals from low to very high priority.[18] In our model, a first step would be to build from existing classification models for care, highlighting no more than four categories that would qualify for support. For example, the first level might correspond to a "mild" MAPLe score, whereas the fourth and highest level would relate to a "very high" score.

17 One issue with existing assessment approaches is that they appear to be based largely on information about limitations in daily living, without much attention being paid to the underlying causes of these limitations. But as noted in the text, it is also possible that the expected cost depends significantly on why a patient is unable to perform certain functions without help. For example, it may be less expensive to care for patients with a given degree of daily-living limitations if their problems are physical rather than cognitive/behavioural, much like Australia's continuing-care financing instrument suggests (see Table 3). Information relevant to the causes of disability, as well as to its extent, can be helpful in designing assessment tools that are both fairer and more precise.

18 Stonebridge, Hermus and Edenhoffer (2015) assign a central role to assessment criteria using Resource Utilization Groups.

## Designing Means-tested Subsidies

Given the estimated cost of providing an acceptable level of care in given care-need categories, the government contribution depends on the strictness of the means test. In general, a means-tested subsidy scheme for patients will consist of three elements. First, there will be a set of maximum subsidies for those with the lowest ability to pay, one for each of the different categories into which patients needing care are classified. Second, the means test requires rules for determining a patient's ability to pay. Third, there also has to be a set of rules that determine how the subsidies will decrease as the patient's ability to pay increases.

### *Maximum Subsidy Levels*

Since retirees in Canada receive Old-Age Security (OAS) benefits and also are eligible for a Guaranteed Income Supplement (GIS), the natural reference point for determining the maximum subsidy for patients in each category would be a person with no significant assets and an income consisting of OAS plus the maximum GIS. The maximum subsidy in each category would be established on the basis of the estimated cost of supplying an acceptable level of care, less any amounts to be paid by patients with the lowest ability to pay.[19]

An important issue here is whether the maximum subsidy should depend on the care recipient's family situation. In existing provincial long-term care or home programs, eligibility for subsidized care either in an institution or in the community may depend on whether or not the potential recipient has access to informal care from family (typically a spouse, or adult children) or friends.

Clearly, rules that deny or reduce subsidies to patients who can rely on spouses or children for care will save provincial governments money. However, they essentially accomplish this by shifting the costs of care from the taxpayers to the patients' families. If guaranteeing access to needed care is considered a collective social responsibility, asking family members to bear the cost of discharging it is not compatible with commonly accepted notions of equity. Thus, while we support a model under which subsidies are differentiated according to patients' ability to pay, we also favour an approach under which, other things being equal, such financial support should be independent of the ability of family members to assume all or part of the care burden.

For institutionalized patients, the principle in most provinces is to require the poorest elderly patients (that is, those with an income that consists of OAS plus the maximum GIS) to contribute their entire income less some "comfort allowance" toward the cost of their own care. Setting a maximum subsidy equal to the full annual cost of institutional care less this contribution would leave these patients no worse off than under the current system.

For patients with less extensive needs who are cared for in the community, the maximum subsidies in each needs category would have to be set in such a way that the poorest individuals would be able to pay for care at acceptable levels and still have enough money left over to pay for food, housing and other basics. To the extent that OAS plus the maximum GIS is considered the minimum acceptable income for elderly individuals, this may imply a maximum subsidy that is close to the full cost of an acceptable level of care.

19 Patients' copayments could be zero for those with the lowest ability to pay (for example, for various kinds of homecare services), but all institutionalized patients, even those with incomes limited to the maximum OAS-GIS, would be expected to contribute toward the cost of their room and board.

*Defining Ability to Pay and Claw-back Rates*

A critical element in a means-tested model is how ability to pay is measured. Most provincial tests consider only patients' incomes – the exceptions are Quebec and Newfoundland and Labrador, which have minimal asset tests in addition to income. Clearly, the starting point for a means test for a self-directed continuing-care plan will be to apply an income test. But it should be kept in mind that other countries also have, over time, been including assets due to concerns over rising public costs (see Appendix A for a further discussion).

Once rules for assessing ability to pay have been determined, the next question that arises is what claw-back rate should be applied – that is, by how much a patient's subsidy should be reduced by a higher ability to pay. We briefly discuss this issue in Appendix B.

## In-cash or In-kind Subsidies

Perhaps the most important change that we propose, in comparison with current provincial models of continuing care, is that subsidized patients would have more scope for arranging their care to suit their particular circumstances. At present, subsidized care, whether in institutions or in the community, is supplied in kind. Although patients may be required to contribute a portion of the cost, the nature of the services they receive is determined by the government plan. The services may be supplied by public agencies or by private firms – for- and not-for-profit – but even when they are supplied privately, the terms are negotiated between the government and the providers, not between the providers and the service recipients.

Under the model we propose, patients would still have the option to receive services in kind but, following the example of Germany and France, persons classified in a given care-needs category could also receive a cash subsidy or voucher that they could use toward the cost of eligible services from independent private providers. A cash subsidy could come at lower value than a voucher, but with fewer restrictions on use.

There are two potential advantages with this approach. First, it gives subsidized patients more scope for arranging care to suit their preferences. Second, it introduces some degree of competition among service providers. Although there is evidence, from the US and elsewhere, to suggest that market competition among private providers may lead to some patients getting care of an unacceptably low quality, the results of studies on this issue are mixed (Comondore et al. 2009). And in countries that have experimented with this approach, there has been extensive discussion about methods for designing incentives for providers to innovate and produce care efficiently, in combination with regulation, oversight and accountability mechanisms to safeguard the quality of care.

*Private Producers and Competition in Continuing-care Markets*

Although some local governments in Canada provide nursing home services, many such services are supplied by private for-profit and not-for-profit firms. However, for subsidized services, whether in institutions or the community, there is little price competition since the terms according to which providers are paid are the same, established in negotiations between the provinces and provider organizations. In the markets where continuing-care services are supplied without subsidies (for example, in private retirement residences or through private-duty nurses), there *is* price competition, as government does not try to control these markets.[20]

20 Needless to say, prices for these services can get rather high, depending on patient needs and desired level of services.

A substantial share of the demand for services in these markets is from patients who have been approved for subsidized services but who cannot get them immediately because there are waiting lists.

Allowing eligible patients to receive subsidies in cash rather than in kind would expand the potential scope for price and quality competition among providers, but the extent to which this would happen would depend on how the system was administered. In principle, cash subsidies could be paid without restrictions on use and with recipients being free to purchase assisted living services from any provider they chose, at whatever prices and other terms that the provider offered.

However, markets for continuing-care services, especially for the elderly, do have special characteristics that justify restrictions and government regulation. In particular, elderly patients who do not have family members to assist them may not be able to search effectively for the best price/quality combinations and make sure that the terms on which they receive care are in accordance with what was agreed initially. Elderly individuals with cognitive limitations are one example of this danger. In countries where eligible patients have the option of receiving cash subsidies, their choices of care provision must be approved by a government agency before the cash subsidies can be paid. Clearly, there should be safeguards of this kind in Canadian provincial programs that offered patients a cash benefit option.

### *Restrictions on Use: Ensuring Quality in a Consumer-Directed System*

In countries that have adopted cash-for-care models for continuing care, the task of ensuring quality has indeed been a major concern. It is not an issue that arises only in the continuing-care sector. Policymakers are accustomed to dealing with the problem in many programs that deliver subsidies in cash or vouchers, as opposed to in kind, including rent supplements, cash transfers for child care, food stamps, etc. In fact, much of the international debate on social policy in general, and continuing care in particular, has focused on the question of service quality, with special attention paid to the conditions on the use of public subsidies in markets where not all consumers are well placed to make informed decisions (Ungerson and Yeandle 2007).

A Canadian model that allowed for a choice between services in kind or cash subsidies would have to take these concerns into account. This would mean imposing some restrictions on the choices of those who select a cash subsidy over receiving care in kind. Unavoidably, the question how extensive these restrictions should be, and their nature, would be highly controversial.

On the one hand, the model should protect vulnerable elderly patients not only against outright fraud and abuse, but also against aggressive marketing practices. On the other hand, the subsidies should give as much flexibility as possible to patients and their families. Equally important, any restrictions should allow new entrants to the industry (including both institutional and community care) a reasonable chance to compete against established providers. A compromise along these lines may involve setting different rules for patients with and without close family that can help them make choices about their care plans, providing standard contracts that cover the legal obligations of independent providers that supply services to patients in different categories, and establishing a government role in ensuring that the quality of care is of an acceptable standard through licensing, quality monitoring and approval of individual care paths.

Other countries assign responsibility for assessments and advice on service choices to specialized providers or agencies whose task is to identify those most capable of using the flexible self-directed options, present them with the greatest range of choices and steer them to qualified caregivers. Those without the capacity to make informed decisions, or without strong family support, are directed toward in-kind services.

A mix of the German system that requires twice-a-year visits with care coordinators to ensure

the appropriate use of funds and the French system that steers recipients toward qualified professionals seems like a practical compromise. The aspect of the German model that offers care in kind and requires individuals to opt out if they want to receive a smaller subsidy in cash is a sensible option that would ensure that the in-kind default option remains the status quo care model.

At the same time, the cash option could require restrictions that push care recipients toward appropriate quality care, making it more like a voucher. Furthermore, it makes sense that as one's care needs rise, so do the restrictions on use and requirements to ensure appropriate care, something that is especially important for patients with varying degrees of cognitive disabilities.

Rollout of a self-directed plan in a Canadian province could be phased in as a test in some regions before the province as a whole. In fact, many provinces are already well-positioned to do this as they already have limited self-directed models.

## Cash-based Subsidies: How Costly to Government?

Clearly, allowing patients to receive cash subsidies rather than services in kind would tend to raise the total cost to provincial governments. One reason is that the cost of continuing care today is limited in part by waiting lists. If access to cash subsidies was unconditional for those with assessed care needs, everyone who is currently wait-listed would presumably apply to receive the subsidy while they were waiting. Rules that restricted the way the cash subsidy could be used might restrict this tendency to some extent, but many people who are waiting for services in kind under existing programs would most likely apply for the cash subsidy and use it to pay for the services they need from private providers in the market.

Waiting lists are both inequitable and inefficient. Eliminating them should be an independent policy objective and will require additional government spending whether or not there exist cash subsidies as an alternative to services in kind. For the longer run, the question is whether the introduction of the proposed subsidies would result in higher costs than a future model in which subsidized services would continue to be provided in kind, but with enough being supplied so that lengthy waiting lists had been eliminated. We see no reason why that should be more expensive, since the cash subsidies in a reformed system would be paid only to patients who would otherwise be entitled to receive services in kind.

In the short and medium term, however, waiting lists for in-kind services will continue to exist and introducing an equivalent cash-subsidy option might raise aggregate costs substantially. A reasonable way of dealing with the fiscal pressure, therefore, would be to work gradually toward reduced waiting lists through a combination of more available in-kind services and partial subsidies for eligible patients. Over time, the subsidy could be raised, at a pace determined by the rate at which costs were increasing and by progress in eliminating waiting lists. An added bonus is that this approach would give additional time to iron out any of the quality oversight concerns discussed earlier.

Currently, the costs of continuing care are less than they otherwise might be because eligibility for both institutional care and community care is sometimes limited to those who do not have a spouse or other family member that can provide the required care. Under the ideal model we propose, patients' eligibility for subsidies would depend solely on their degree of disability and health impairment and on their means, not on their family situation. As a result, some patients not entitled to subsidized care in kind under the present system would be eligible for either subsidies in kind or in cash.

Clearly, such a shift would raise the cost of continuing care. Nevertheless, we believe there is a strong equity argument for it: denying subsidies for access to services to those who cannot pay for them but have a family member who can supply these

services is tantamount to requiring these unpaid caregivers to take on a cost that otherwise would be born collectively by taxpayers.

Moreover, a model with an option of cash subsidies in lieu of in-kind services would encourage more efficient use of society's labour. Spouses or adult children would only choose to be caregivers (and keep the subsidy in the family) when the income they could earn in other jobs was relatively low, while higher-earning family members would opt for in-kind services or use the cash subsidy to pay for private services instead.

That said, for cost reasons, other countries have reduced the size of the cash subsidy based on the availability of informal family care. Given the fiscal constraints that Canadian provinces already face – and the overarching priority of cost control in current health systems – they might initially choose to pay cash subsidies at reduced rates to patients with a spouse or other family member who could supply their care. Such a compromise might increase the chances of bringing about a functioning model. It must also be recognized that the task of ensuring that patients receive care of acceptable quality can become more difficult when the provider is a family member or close relative, so there is justification for somewhat more restrictive rules with respect to the cash subsidies that are paid patients who plan to rely on family caregivers than for those who buy needed services from outside providers.[21]

Although making subsidized care independent of patients' family situations, and allowing recipients to opt for cash subsidies could imply considerable additional cost to provincial governments, the reforms we advocate along these lines should not be considered in isolation but in conjunction with our proposals for means-testing, which obviously would help reduce government costs. Nonetheless, how to limit the impact of a self-directed plan on government budgets is one of the more complicated aspects of the model we propose; international experiences have shown the significance of this problem.

## CONCLUSION

The state of continuing care is troublesome on a number of fronts, including the rising stress on caregivers, long waits in hospital beds, and unmet homecare needs. In a little more than a decade, these pressures will become even more severe when the babyboomers reach ages where their demand for care rises sharply. Given how poorly our system is coping with the demand for continuing-care services today, Canadians should be seriously concerned about this issue – and most polls confirm that they are.

A number of other countries face the same challenges but have been much more proactive in establishing a framework for supporting greater independence among the elderly. In doing so, they have recognized that shifting more services to the home and community is a key goal. Compared to most other advanced health systems, Canadian provinces also are outliers by not having moved toward self-directed care models for elderly recipients. Reforms along the lines that have been tried in these countries could go a long way toward resolving some of the major issues affecting our system. The experience abroad shows several countries as having been rather successful in encouraging more substitution of homecare for institutional care and in boosting patient satisfaction by giving individuals and families a greater say in their care packages.

21 Although France restricts the use of the APA for care provided by a spouse, it does allow it to be transferred for care provided by other family members.

Two of the biggest challenges for governments contemplating more cash-based, self-directed benefits for continuing-care services are the cost impact and ensuring quality. All countries we studied have, however, managed to overcome these challenges, at least to some degree, through restrictions on the size of the subsidy to those with substantial means or available family help and by establishing oversight in the use of the subsidy. With respect to the latter issue, however, care must be taken so that attempts to impose quality-of-care standards do not result in policies that reduce competition and raise costs. For example, they should not take the form of rules that are overly demanding with respect to what formal qualifications are required of personal support workers in home care, or that impose burdensome restrictions on what institutions are allowed to supply subsidized residential care.

Establishing a new comprehensive self-directed model to meet these challenges requires:

- an assessment system;
- means testing;
- a funding mechanism that is based on need but controls government costs;
- an oversight system to ensure quality and enforce restrictions on use; and
- establishing who will oversee, coordinate and be accountable for care.

Canadian provinces' one-size-fits-all approach to helping seniors continues to steer individuals toward institution-based care even when they would prefer to receive it elsewhere. Furthermore, it is not clear that the pace in which governments are shifting resources from institutions toward homecare will be able to keep up with rising, and increasingly varied, future demand. Going forward, Canada must encourage a greater role for patients in choosing their care paths, and doing so means expanding access to a more self-directed system.

## Appendix A: Including Income and Assets in Means Tests for Continuing Care

Means tests that determine the eligible level of aged-care subsidy should be based on both income and assets, even though this makes it more complicated to administer (Blomqvist and Busby 2014). Although there is no commonly accepted definition of ability to pay, it should reflect the resources that a person has available to finance present and future consumption. While current income may be a reasonable proxy for ability to pay among persons of working age, it is less so for retirees. Persons with large accumulated assets can sustain a high standard of living even if their current income is low. Moreover, as people become older they can afford to finance consumption in excess of their current income, even if this means that they will gradually deplete their accumulated assets.

The means-testing process should be as simple as possible, but it must also be fair. To this end, information on assets should include not only income-earning wealth but also assets that don't yield income that has to be declared for tax purposes, such as a homeowner's principal residence. The information on assets would be used together with the income from the applicant's tax return to create an adjusted measure of annual ability to pay that would add a fraction of their assets (net of liabilities) to declared income.

A related issue is how the means-testing rules should be influenced by the patient's family situation or, specifically, whether he or she has a spouse living in the community. In the Canadian tax-and-transfer system, a married couple is treated differently than two separate individuals, and assets such as pension funds and matrimonial homes are often owned jointly. There is therefore a case for having means-testing rules with special provisions for the spouses of continuing-care patients.

## Appendix B: Considerations in Designing Clawback Rates

In several provinces where the ability to pay is defined on the basis of a patient's income, the amounts that institutionalized patients have to contribute toward the cost of their own care rises by one dollar for each additional dollar of income that they declare, up to a maximum. Implicitly, this rule amounts to a clawback rate of 100 percent, since the subsidy that the government contributes toward the cost is reduced dollar for dollar as the patient's income rises.

However, a continuing-care clawback rate can be less than 100 percent. For example, in Saskatchewan it is 50 percent, meaning that the subsidy is reduced by 50 cents for each dollar increase in a patient's declared income, down to a specified minimum. When an applicant's annual ability to pay is calculated on the basis of both declared income and assets, the clawback rate is applied to the adjusted ability-to-pay measure. In this way, the subsidy will decrease with an increase in the person's net assets as well as with an increase in his or her declared income.

The rate at which the annual subsidy will decrease with an increase in net assets will depend both on the clawback rate and on the fraction of a person's net assets that is added to income when the adjusted ability to pay is calculated. For example, if the clawback rate is 50 percent and 30 percent of a person's net assets are included when this measure is calculated, then the annual subsidy will decrease by 15 cents for each additional dollar of assets. Thus, the government subsidy for patients in different categories will depend both on the clawback rate and on the fraction of net assets that are included when ability to pay is calculated.

Other things being equal, government cost is minimized if the clawback rate is set at 100 percent and ability to pay is calculated by adding 100 percent of a person's net assets to his or her declared income. We share the view of those who consider a clawback rate of 100 percent unfair to retirees who have accumulated at least some assets to pay for their own needs in old age. Nevertheless, a high clawback rate reduces the burden on government budgets and probably does not have very significant incentive effects on working-age savings since it only affects those who will need care when they are old. For this reason, we think a relatively high rate, 50 percent or more, can be justified. For the same reason, we also favour inclusion of a substantial share of a person's net assets when ability to pay is calculated.

A system of subsidies that are subject to clawbacks may also specify minimum subsidy levels, so that even those with the highest ability to pay are eligible for at least some subsidy. A minimum of this type is implicit in most current systems of long-term care as they specify maximum patient charges that are lower than the full cost to the government, both for care that is supplied to patients in nursing homes and in the community. However, we see no strong argument in favour of minimum subsidies of this kind – there is no reason why wealthy individuals should not pay the full cost of their care as long as their resources allow them to do so.

Another important issue with respect to clawback rules is how to deal with cases where a patient has a spouse (typically also elderly) who lives in the community. Special rules for assessing the patient's ability to pay may then be needed to avoid undue hardship for the spouse, for example, in cases when an institutionalized patient's pension constitutes the family's main source of income. Similarly, although it is reasonable to take a valuable family home into account when assessing ability to pay, allowances can be made in cases when it is occupied by a spouse so that high payments for long-term care do not force him or her to sell the home.

## REFERENCES


Australia. 2013. "Consumer Directed Care – Evaluation of Pilot Program." Australian Government: Department of Health. September. Available at: http://webarchive.nla.gov.au/gov/20140802120444/http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cdc-evaluation-pilot-program [Date of Access: October 10, 2015].

———. 2014. "Aged Care in Australia: Part I – Policy, Demand and Funding." ARC Centre of Excellence in Population Ageing Research. CEPAR Research Brief 2014/01.

Blomqvist, Ake, and Colin Busby. 2014. *Paying for the Boomers: Long-term Care and Intergenerational Equity*. Commentary 415. Toronto: C.D. Howe Institute. September.

Canadian Home Care Association. 2009. "Portraits of Home Care in Canada: 2008." Canadian Home Care Association. March.

———. 2013. "Portraits of Home Care in Canada: 2013." Canadian Home Care Association. March.

Carlson, Barbara, et al. 2007. "Effects of Cash and Counseling on Personal Care and Well-Being." *Health Services Research*. Vol. 42 (1 pt 2), 467-487.

Columbo, Francesca, et al. 2011. Help Wanted? Providing and Paying for Long-term Care. OECD Health Policy Studies. Paris: OECD.

Comondore, et al., 2009. "Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis." *British Medical Journal* 4:339 August.

Donner, Gail, et al., "Bringing Care Home." Report of the Expert Group on Home and Community Care. Toronto: Government of Ontario. March.

Fast, Janet. 2015. "Caregiving for Older Adults with Disabilities: Present Costs, Future Challenges. Institute for Research on Public Policy. December.

France. 2015. Information on Benefits and Services to the Elderly. APA. Available at: https://www.service-public.fr/particuliers/vosdroits/N392 [Date of Access: June 15, 2015].

———. 2008. Classification Guide for French Care Needs (AGGIR). Available at http://www.cnsa.fr/documentation/guide_aggir_2008.pdf [Date of Access: June 15, 2015].

Grignon, Michel, and Nicole Bernier. 2012. "Financing Long-term Care in Canada." IRPP Study 33. Montreal: Institute for Research in Public Policy.

Hirdes, John, Jeff Poss, and Nancy Curtin-Telegdi. 2008. "The Method For Assigning MAPLe: A New Decision Support System for Allocating Home Care Resources." *BMC Medicine* Vol. 6, no. 9.

Le Bihan, Blanche, and Claude Martin. 2013. "Steps Toward a Long-term Care Policy in France: Specificities, Processes and Actors." Chapter in *Reforms in Long-term Care Policies in Europe: Investigating Institutional Change and Social Impacts*. Costanzo Ranci and Emmanuele Pavolini eds. New York.

Meagher, Gabrielle, and Marta Szebehely. 2013. "Long-term Care in Sweden: Trends, Actors, and Consequences." Chapter in *Reforms in Long-term Care Policies in Europe: Investigating Institutional Change and Social Impacts*. Costanzo Ranci and Emmanuele Pavolini eds. New York.

OECD Health Statistics. 2012.

Pavolini, Emmanuele, and Costanzo Ranci. 2013. "Reforms in Long-term Care Policies in Europe: An Introduction." Chapter in *Reforms in Long-term Care Policies in Europe: Investigating Institutional Change and Social Impacts*. Costanzo Ranci and Emmanuele Pavolini eds. New York.

Schölkopf, Martin. 2013. "Long-term Care Insurance in Germany." Presentation at the Conference on Managing Innovation and Reform in Healthcare. University of Minnesota. Minneapolis. November 13. Available at http://cges.umn.edu/docs/Schoelkopf_LTCinGermany.pdf [Date of Access: June 22, 2015].

Shultz, Erika. 2010. "The Long-term Care System for the Elderly in Germany." ENEPRI Research Report No. 78. Assessing Needs of Care in European Nations. June.

Sinha, Maire. 2013. "Portrait of Caregivers, 2012." Analytical Paper. Spotlight on Canadians: Results from the General Social Survey. Ottawa: Statistics Canada. Social and Aboriginal Statistics Division. Catalogue no. 89-652-X – No. 001. September.

Stadnyk, Robin L. 2009. "Three Policy Issues in Deciding the Cost of Nursing Home Care: Provincial Differences and How They Influence Elderly Couple's Experiences." *Healthcare Policy* 5(1). pp: 132-44.

Statistics Canada. 2015. "A Profile of Persons with Disabilities Among Canadians Aged 15 and older, 2012." Ottawa: Statistics Canada. March.

Stonebridge, Carole, Greg Hermus, and Kalus Edenhoffer. 2015. "Future Care for Seniors: A Status Quo Forecast." Conference Board of Canada. November.

Sutherland, Jason, and R. Trafford Crump. 2011. "Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada." Canadian Health Services Research Foundation.

Sweden. 2014. Information on Attendance Allowance. Available at: https://www.forsakringskassan.se/wps/wcm/connect/058f3bd1-e258-408e-bd05-a9d5b2d8351f/assistansersattning_eng2014.pdf?MOD=AJPERES [Date of Access: June 28, 2015].

Turcotte, Martin. 2014. "Canadians with Unmet Home Care Needs." Statistics Canada Study no. 75-006-X. Ottawa: Statistics Canada.

Ungerson, Clare, and Sue Yeandle. 2007. "Dilemmas, Contradictions and Change." Chapter in *Cash for Care in Developed Welfare States*. Clare Ungerson and Sue Yeandle eds. Economic and Social Research Council. London: Plagrave Macmillan.

Wiener, Joshua, Wayne Anderson, and Galina Khatutsky. 2007. "Are Consumer Directed Home Care Beneficiaries Satisfied? Evidence from Washington State." *The Gerontologist*. Vol 47 (6). 763-774.

NOTES:

## Recent C.D. Howe Institute Publications

| | |
|---|---|
| January 2016 | Benjamin Dachis. "National Priorities 2016 – Getting More Buildings for our Bucks: Canadian Infrastructure Policy in 2016." C.D. Howe Institute E-Brief. |
| January 2016 | Benjamin Dachis. "National Priorities 2016 – The Future of Canadian Energy Policy." C.D. Howe Institute E-Brief. |
| December 2015 | Benjamin Dachis, William B.P. Robson, and Aaron Jacobs. "A Crisis of Capital: Canadian Workers Need More Tools, Buildings and Equipment" C.D. Howe Institute E-Brief. |
| December 2015 | Schwanen, Daniel, Dan Ciuriak, and Jeremy Kronick. *Opening up New Trade Routes for Financial Services: Canada's Priorities.* C.D. Howe Institute Commentary 442. |
| December 2015 | Alexander, Craig, and Paul Jacobson. *Mortgaged to the Hilt: Risks From The Distribution of Household Mortgage Debt.* C.D. Howe Institute Commentary 441. |
| December 2015 | Laurin, Alexandre. "Shifting the Federal Tax Burden to the One-Percenters: A Losing Proposition." C.D. Howe Institute E-Brief. |
| December 2015 | Hale, Geoffrey, and Yale Belanger. *From "Social Licence" to "Social Partnership": Promoting Shared Interests for Resource and Infrastructure Development.* C.D. Howe Institute Commentary 440. |
| November 2015 | Found, Adam, Peter Tomlinson, and Benjamin Dachis. "Business Tax Burdens in Canada's Major Cities: The 2015 Report Card." C.D. Howe Institute E-Brief. |
| November 2015 | Alexander, Craig, and Alexandre Laurin. "Tax Reform Priorities for Canada: Creating More Income to Go Around?" C.D. Howe Institute E-Brief. |
| November 2015 | Dachis, Benjamin, and William B.P. Robson. *Building Better Budgets: Canada's Cities Should Clean Up their Financial Reporting.* C.D. Howe Institute Commentary 439. |
| November 2015 | Veillard, Jeremy, Omid Fekri, Irfan Dhalla, and Niek Klazinga. *Measuring Outcomes in the Canadian Health Sector: Driving Better Value from Healthcare.* C.D. Howe Institute Commentary 438. |
| October 2015 | Anand, Anita. "The Future of Poison Pills in Canada: Are Takeover Bid Reforms Needed?" C.D. Howe Institute E-Brief. |

### Support the Institute

For more information on supporting the C.D. Howe Institute's vital policy work, through charitable giving or membership, please go to www.cdhowe.org or call 416-865-1904. Learn more about the Institute's activities and how to make a donation at the same time. You will receive a tax receipt for your gift.

### A Reputation for Independent, Nonpartisan Research

The C.D. Howe Institute's reputation for independent, reasoned and relevant public policy research of the highest quality is its chief asset, and underpins the credibility and effectiveness of its work. Independence and nonpartisanship are core Institute values that inform its approach to research, guide the actions of its professional staff and limit the types of financial contributions that the Institute will accept.

For our full Independence and Nonpartisanship Policy go to www.cdhowe.org.

C.D. HOWE
INSTITUTE

67 Yonge Street, Suite 300,
Toronto, Ontario
M5E 1J8

Canadian Publication Mail Sales
Product Agreement #40008848